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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2008-255
LAURA LANE NICHOLSON P.O. Box 2418 Ocean Shore, Washington 98569 Registered Nurse License No. 479144	OAH No.
Respondent.	**DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about March 3, 2008, Complainant Ruth Ann Terry, M.P.H., R.N., in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2008-255 against Laura Lane Nicholson (Respondent) before the Board of Registered Nursing.

2. On or about May 31, 1992, the Board of Registered Nursing (Board) issued Registered Nurse License No. 479144 to Respondent. The Registered Nurse License expired on April 30, 2006, and has not been renewed.

3. On or about March 20, 2008, Carol Grays, an employee of the Department of Justice, served by Certified Mail and First Class Mail a copy of Accusation No. 2008-255, Statement to Respondent, Request for Discovery, Notice of Defense forms, Discovery Statutes, and Disciplinary Guidelines to Respondent's address of record with the Board, which was 1819

47th Avenue, San Francisco, California 94122. On or about April 24, 2008, the aforementioned documents were returned by the U.S. Postal Service marked "Unclaimed." A copy of the Accusation is attached as Exhibit A, and is incorporated herein by reference.

4. On or about April 29, 2008, Shontaine McElroy, an employee of the Department of Justice, served by Certified Mail and First Class Mail a copy of Accusation No. 2008-255, Statement to Respondent, Request for Discovery, Notice of Defense forms, Discovery Statutes, and Disciplinary Guidelines to Respondent's current address of record with the Board, which is P.O. Box 2418, Ocean Shore, Washington 98569. On or about May 7, 2008, the aforementioned documents were returned by the U.S. Postal Service marked "Box Closed Unable to Forward Return to Sender."

5. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

6. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

7. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2008-255.

8. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

9. Pursuant to its authority under Government Code section 11520, the Board finds that Respondent is in default and has waived her right to a hearing. The Board will take action without further hearing and, based on the evidence on file herein, determines that the allegations in Accusation No. 2008-255 are true.

10. The total costs for investigation and enforcement of this case are $2,507.25 as of June 17, 2008.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Laura Lane Nicholson has subjected her Registered Nurse License No. 479144 to discipline.

2. Service of Accusation No. 2008-255 and related documents was proper and in accordance with the law.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation:

a. Business and Professions Code (Code) section 2761(a) on the grounds of unprofessional conduct, as defined by Code section 2762(e), in that while employed as a registered nurse at San Francisco General Hospital in San Francisco, California, Respondent made grossly incorrect, or grossly inconsistent entries in hospital and patient records pertaining to controlled substances and/or dangerous drugs in the following respects:

Patient I[1]: Between September 28, 2004 and January 28, 2005, Respondent removed and signed out from the "SureMed" system one hundred and eighty two (182) 30/300 mg tablets of Tylenol with Codeine #3 (Tylenol #3) for Patient I. When Respondent signed out the controlled substance, there was no valid doctor's order to do so, as Patient I had been discharged from the hospital on September 10, 2004. Respondent failed to chart administration of the Tylenol 3 and failed to chart wastage or otherwise account for the 182 Tylenol 3 tablets she signed out for Patient I between September 28, 2004 and January 28, 2005.

1. All patients are identified by Roman Numerals in order to preserve patient confidentiality.

Patient II: Between December 17, 2004 and December 27, 2004, Respondent removed and signed out from the "SureMed" system twenty (20) 30/300 mg tablets of Tylenol #3 tablets for Patient II. When Respondent signed out the controlled substance, there was no valid doctor's order to do so, as Patient II had been discharged from the hospital on December 15, 2004. Respondent failed to chart administration of the Tylenol 3 and failed to chart wastage or otherwise account for the 20 Tylenol 3 tablets she signed out for Patient II between December 17, 2004 and December 27, 2004.

Patient III: Between December 4, 2004 and January 4, 2005, Respondent removed and signed out from the "SureMed" system forty (40) 30/300 mg tablets of Tylenol #3 tablets for Patient III. When Respondent signed out the controlled substance, there was no valid doctor's order to do so, as Patient III had been discharged from the hospital on December 3, 2004. Respondent failed to chart administration of the Tylenol 3 and failed to chart wastage or otherwise account for the 40 Tylenol 3 tablets she signed out for Patient III between December 4, 2004 and January 4, 2005.

Patient IV: Between December 31, 2004 and January 24, 2005, Respondent removed and signed out from the "SureMed" system sixty-five (65) 30/300 mg tablets of Tylenol #3 for Patient IV. When Respondent signed out the controlled substance for Patient IV, there was no valid doctor's order to do so, as Patient IV had been discharged from the hospital on December 29, 2004. Respondent failed to chart administration of the Tylenol 3 and failed to chart wastage or otherwise account for the 65 Tylenol 3 tablets she signed out for Patient IV between December 31, 2004 and January 28, 2004.

On January 20, 2005, at 12:15 a.m., Respondent removed and signed out from the "SureMed" system two vials of Oxycontin 10 u/ml for Patient IV. When Respondent signed out the controlled substance for Patient IV, there was no valid doctor's order to do so, as Patient IV had been discharged on December 29, 2004. Respondent failed to chart administration of the Oxycontin 10 u/ml, and failed to chart wastage or

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otherwise account for the two vials of Oxycontin 10 u/ml she signed out for Patient IV on January 20. 2005.

On January 7, 2005, at 12:13 a.m., Respondent removed and signed out from the "SureMed" system one 600 mg tablet of Ibuprofen. On January 11, 2005, at 3:24 p.m., Respondent removed and signed out from the "SureMed" system two 400 mg tablets of Ibuprofen. When Respondent signed out these medications for Patient IV, there was no valid doctor's order to do so, as Patient IV had been discharged on December 29, 2004. Respondent failed to chart administration of the medication, and failed to chart wastage or otherwise account for the Ibuprofen she signed out for Patient IV on January 7, 2005 and January 11, 2005.

Patient V: Between December 17, 2004 and January 28, 2005, Respondent removed and signed out from the "SureMed" system eighty-eight (88) tablets of 30/300 mg Tylenol #3 tablets for Patient V. When Respondent signed out the controlled substance for Patient V, there was no valid doctor's order to do so, as Patient V had been discharged from the hospital on December 29, 2004. Respondent failed to chart administration of the Tylenol 3, and failed to chart wastage or otherwise account for the 88 Tylenol #3 tablets she signed out for Patient V between December 17, 2004 and January 28, 2005.

On January 7, 2005, at 12:52 a.m., Respondent removed and signed out from the "SureMed" system two tablets of 400 mg Ibuprofen. On January 7, 2005, at 12:53 a.m., Respondent removed and signed out from the "SureMed" system one tablet of 600 mg Ibuprofen. When Respondent signed out these medications for Patient IV, there was no valid doctor's order to do so, as Patient IV had been discharged on December 29, 2004. Respondent failed to chart administration of the medication, and failed to chart wastage or otherwise account for the three tablets of Ibuprofen she signed out for Patient V on January 7, 2005.

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b. Code section 2761(a) on the grounds of unprofessional conduct, as defined by Code section 2762(a), in that, as set forth above, and on or about September 28, 2004 to on or about January 28, 2005, she committed the following acts:

She obtained Tylenol with Codeine #3 (Acetaminophen with Codeine #3), a controlled substance, by fraud, deceit, misrepresentation, or subterfuge, by taking the drugs from hospital supplies, in violation of Health and Safety Code section 11173.

She possessed Tylenol with Codeine #3 (Acetaminophen with Codeine #3), a controlled substance, in violation of Code section 4060.

She obtained Oxycontin (Oxycodone), a controlled substance, by fraud, deceit, misrepresentation, or subterfuge, by taking the drugs from hospital supplies, in violation of Health and Safety Code section 11173.

She possessed Oxycontin (Oxycodone), a controlled substance, in violation of Code section 4060.

ORDER

IT IS SO ORDERED that Registered Nurse License No. 479144, heretofore issued to Respondent Laura Lane Nicholson, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on September 18, 2008.

It is so ORDERED August 18, 2008

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FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

Attachment:

Exhibit A: Accusation No. 2008-255

Exhibit A

Accusation No. 2008-255

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of the State of California
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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LAURA LANE NICHOLSON 1819 47th Avenue San Francisco, California 94122 Registered Nurse License No. 479144 Respondent.	Case No. 2008-255 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about May 31, 1992, the Board of Registered Nursing issued Registered Nurse License Number 479144 to Laura Lane Nicholson (Respondent). The Registered Nurse License expired on April 30, 2006, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761(a) of the Code states, in pertinent part, that the Board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct, which includes, but is not limited to certain enumerated conduct.

7. Section 2762 of the Code states, in pertinent part, that "[i]n addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist, administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

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8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. **Tylenol with Codeine #3** is a Section III controlled substance as designated by Health and Safety Code section 11056(e)(2) and is a dangerous drug pursuant to Code section 4022. **Tylenol with Codeine #3** is a brand name of **Acetaminophen with Codeine #3.**

10. **Oxycontin** is a Section II controlled substance as designated by Health and Safety Code section 11055(b)(1)(N) and a dangerous drug pursuant to Code section 4022. **Oxycontin** is a brand name of **Oxycodone**.

11. **Ibuprofen** is a dangerous drug pursuant to Code section 4022.

FIRST CAUSE FOR DISCIPLINARY ACTION

(Falsify, Make Incorrect, Inconsistent, or Unintelligible Entries In Patient/Hospital Records)

12. Respondent has subjected her license to disciplinary action under section 2761(a) of the Code on the grounds of unprofessional conduct, as defined by Code section 2762(e), in that while employed as a registered nurse at San Francisco General Hospital in San Francisco, California, she made grossly incorrect, or grossly inconsistent entries in hospital and patient records pertaining to controlled substances and/or dangerous drugs in the following respects:

a. **Patient I**[1]: Between September 28, 2004 and January 28, 2005,

1. All patients are identified by Roman Numerals in order to preserve patient confidentiality. The medical record numbers of these patients will be disclosed pursuant to a request for discovery.

Respondent removed and signed out from the "SureMed"[2] system one hundred and eighty two (182) 30/300 mg tablets of Tylenol with Codeine #3 (Tylenol #3) for Patient I. When Respondent signed out the controlled substance, there was no valid doctor's order to do so, as Patient I had been discharged from the hospital on September 10, 2004. Respondent failed to chart administration of the Tylenol 3 and failed to chart wastage or otherwise account for the 182 Tylenol 3 tablets she signed out for Patient I between September 28, 2004 and January 28, 2005.

b. **Patient II**: Between December 17, 2004 and December 27, 2004, Respondent removed and signed out from the "SureMed" system twenty (20) 30/300 mg tablets of Tylenol #3 tablets for Patient II. When Respondent signed out the controlled substance, there was no valid doctor's order to do so, as Patient II had been discharged from the hospital on December 15, 2004. Respondent failed to chart administration of the Tylenol 3 and failed to chart wastage or otherwise account for the 20 Tylenol 3 tablets she signed out for Patient II between December 17, 2004 and December 27, 2004.

c. **Patient III**: Between December 4, 2004 and January 4, 2005, Respondent removed and signed out from the "SureMed" system forty (40) 30/300 mg tablets of Tylenol #3 tablets for Patient III. When Respondent signed out the controlled substance, there was no valid doctor's order to do so, as Patient III had been discharged from the hospital on December 3, 2004. Respondent failed to chart administration of the Tylenol 3 and failed to chart wastage or otherwise account for the 40 Tylenol 3 tablets she signed out for Patient III between December 4, 2004 and January 4, 2005.

d. **Patient IV**: Between December 31, 2004 and January 24, 2005, Respondent removed and signed out from the "SureMed" system sixty-five (65) 30/300 mg tablets of Tylenol #3 for Patient IV. When Respondent signed out the controlled substance for Patient IV, there was no valid doctor's order to do so, as Patient IV had been discharged from the hospital

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2. A SureMed machine is a drug-dispensing machine somewhat akin to a "medication cart." However, a SureMed machine is security controlled in that a licensee can only access medications through the use of a log-on name and secret password.

on December 29, 2004. Respondent failed to chart administration of the Tylenol 3 and failed to chart wastage or otherwise account for the 65 Tylenol 3 tablets she signed out for Patient IV between December 31, 2004 and January 28, 2004.

On January 20, 2005, at 12:15 a.m., Respondent removed and signed out from the "SureMed" system two vials of Oxycontin 10 u/ml for Patient IV. When Respondent signed out the controlled substance for Patient IV, there was no valid doctor's order to do so, as Patient IV had been discharged on December 29, 2004. Respondent failed to chart administration of the Oxycontin 10 u/ml, and failed to chart wastage or otherwise account for the two vials of Oxycontin 10 u/ml she signed out for Patient IV on January 20. 2005.

On January 7, 2005, at 12:13 a.m., Respondent removed and signed out from the "SureMed" system one 600 mg tablet of Ibuprofen. On January 11, 2005, at 3:24 p.m., Respondent removed and signed out from the "SureMed" system two 400 mg tablets of Ibuprofen. When Respondent signed out these medications for Patient IV, there was no valid doctor's order to do so, as Patient IV had been discharged on December 29, 2004. Respondent failed to chart administration of the medication, and failed to chart wastage or otherwise account for the Ibuprofen she signed out for Patient IV on January 7, 2005 and January 11, 2005.

e. **Patient V:** Between December 17, 2004 and January 28, 2005, Respondent removed and signed out from the "SureMed" system eighty-eight (88) tablets of 30/300 mg Tylenol #3 tablets for Patient V. When Respondent signed out the controlled substance for Patient V, there was no valid doctor's order to do so, as Patient V had been discharged from the hospital on December 29, 2004. Respondent failed to chart administration of the Tylenol 3, and failed to chart wastage or otherwise account for the 88 Tylenol #3 tablets she signed out for Patient V between December 17, 2004 and January 28, 2005.

On January 7, 2005, at 12:52 a.m., Respondent removed and signed out from the "SureMed" system two tablets of 400 mg Ibuprofen. On January 7, 2005, at 12:53 a.m., Respondent removed and signed out from the "SureMed" system one tablet of 600 mg Ibuprofen. When Respondent signed out these medications for Patient IV, there was no valid doctor's order to do so, as Patient IV had been discharged on December 29, 2004. Respondent failed to chart

administration of the medication, and failed to chart wastage or otherwise account for the three tablets of Ibuprofen she signed out for Patient V on January 7, 2005.

SECOND CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances)

13. Complainant realleges the allegations set forth in Paragraph 12 above, which are herein incorporated by reference as though fully set forth.

14. Respondent has subjected her license to discipline under section 2761(a) of the Code on the grounds of unprofessional conduct, as defined by Code section 2762(a), in that, on or about September 28, 2004 to on or about January 28, 2005, she committed the following acts:

a. She obtained Tylenol with Codeine #3 (Acetaminophen with Codeine #3), a controlled substance, by fraud, deceit, misrepresentation, or subterfuge, by taking the drugs from hospital supplies, in violation of Health and Safety Code section 11173.

b. She possessed Tylenol with Codeine #3 (Acetaminophen with Codeine #3), a controlled substance, in violation of Business and Professions Code section 4060.

c. She obtained Oxycontin (Oxycodone), a controlled substance, by fraud, deceit, misrepresentation, or subterfuge, by taking the drugs from hospital supplies, in violation of Health and Safety Code section 11173.

d. She possessed Oxycontin (Oxycodone), a controlled substance, in violation of Business and Professions Code section 4060.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 479144, issued to Laura Lane Nicholson.

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2. Ordering Laura Lane Nicholson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/3/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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